DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

Center for Substance Abuse Treatment

TARGETED CAPACITY EXPANSION PROGRAM FOR SUBSTANCE ABUSE TREATMENT AND HIV/AIDS SERVICES

(SHORT TITLE: TCE /HIV)

Guide for Applicants (GFA) No. TI 00 - 005
Part I - Programmatic Guidance

Catalog of Federal Domestic Assistance No. 93.230

Under the authority of Section 501(d) (5) of the Public Health Service Act, as amended (42 U.S.C. 290aa), and subject to the availability of funds, the SAMHSA Center for Substance Abuse Treatment will accept applications in response to this Guidance for Applicants for the receipt date of June 13, 2000.

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Part I - PROGRAMMATIC GUIDANCE
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[Note to Applicants: In order to prepare an application, PART II, "General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements" (February 1999 edition), must be used in conjunction with this document, PART I, "Programmatic Guidance."]

Section I - OVERVIEW

The primary goal of the TCE/HIV program is to reduce the spread of substance abuse related HIV/AIDS and infectious diseases in African American, Hispanic/Latino and other racial/ethnic minority communities by addressing gaps in treatment capacity and access, and by expanding or enhancing the core capabilities of substance abuse treatment programs to provide effective services for their clients and/or their families with specific needs attributed to HIV/AIDS, STDs, TB, or hepatitis B and C.

Purpose

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) announces the availability of funds for grants to enhance and expand substance abuse treatment and HIV/AIDS services in African American, Hispanic/Latino and/or other racial/ethnic minority communities highly affected by the twin epidemics of substance abuse and HIV/AIDS. This Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services, or TCE/HIV, seeks to address gaps in substance abuse treatment capacity by increasing the accessibility and availability of substance abuse treatment and HIV/AIDS related services (including treatment for STDs, TB and hepatitis B and C)to African American, Hispanic/Latino and/or other racial/ethnic minority substance abusers. This Guidance for Applicants (GFA) solicits applications for innovative targeted responses to the epidemic of substance abuse and related HIV/AIDS, and is consistent with Congressional report language. This GFA is a reissuance (with revisions) of a prior GFA by the same title,"Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services," GFA No. TI 99-004.

Note: SAMHSA CSAT has two FY 2000 programs under which funding is available for substance abuse treatment and HIV/AIDS services. The two programs are: PA 00-001 - Grants to Expand Substance Abuse Treatment Capacity in Targeted Areas of Need, and this program, TI 00-005 - Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services. The eligibility requirements vary for each program; therefore,

potential applicants must refer to the specific announcement to determine if they are eligible to apply.

Eligibility

Applications may be submitted by public and domestic private non-profit and for-profit entities, such as units of State or local government and grassroots and/or community-based organizations that have the capacity to provide substance abuse treatment services to African American, Hispanic/Latino and/or other racial/ethnic minority communities. SAMHSA's CSAT encourages applications from substance abuse treatment programs that have a good record of reaching and serving hardcore, chronic drug users and their sex/needle-sharing partner(s) and facilitating their entry into substance abuse treatment. Targeted communities must be located in a metropolitan statistical area (MSA) with an annual AIDS case rate of or greater than 15/100,000 or in a State with an annual AIDS case rate of or greater than 10/100,000. SAMHSA CSAT's intention is to target areas at highest risk for HIV transmission. In the absence of consistent reporting of HIV data by all jurisdictions, the best indicator of the magnitude of the epidemic is AIDS case rates derived from CDC HIV/AIDS Surveillance Reports. (See Appendix A for CDC annual case rates in States and metropolitan areas.)

In addition to the basic requirements for eligibility, providers of services must be in compliance with all local, city, county, and/or State licensing and/or accreditation/certification requirements, and must also have been providing substance abuse treatment services for a minimum of two years prior to the date of this application. Licensure and any documentation of accreditation/certification as well as documentation of two years experience must be provided with the application in Appendix 1 "Certification of Experience/Licensure/Accreditation." Without documentation of licensure/accreditation (or a statement as to why licensure/accreditation is not required by the local/State government) and at least two years of experience as of the application receipt date, applications will be considered ineligible and will not be considered for peer review. SAMHSA believes that only existing experienced providers have the infrastructure and expertise to provide services and to address emerging and unmet needs as quickly as possible.

Availability of Funds

Approximately $16.0 million will be available to support approximately 30-40 awards under this GFA in FY 2000. Awards are expected to range from $100,000 to $500,000 (direct and indirect costs) for projects directed to the following substance abusing populations in African American, Hispanic/Latino and/or other racial/ethnic minority communities:

- Women and women and their children
- Adolescents
- Injecting drug users including men who have sex with men and inject drugs (MSM)
- Men or women who have been released from prisons and jails

Only one application seeking support for the same programmatic activity with the same population may be submitted to SAMHSA.

Prohibitions: Federal funds awarded under this GFA may not be used to carry out syringe exchange programs, such as the purchase and distribution of syringes and/or needles, nor can funds authorized under this program be used to pay for pharmacologics for antiretroviral therapy, STDs, TB and hepatitis B and C.

Period of Support

Support may be requested for a period of up to three (3) years. Annual awards will be made subject to continued availability of funds and progress in meeting the goals and objectives of this program.

Section II - PROGRAM DESCRIPTION

Supporting Documentation

SAMHSA is soliciting applications from organizations that have a demonstrated capacity to provide substance abuse treatment services to African American, Hispanic/Latino and/or other

racial/ethnic minority communities. In addition to providing substance abuse services, the applicants must secure linkages with primary care, mental health, and HIV/AIDS providers as well as with various indigenous community-based organizations with experience in providing services to these communities. Consequently, SAMHSA is interested in applications that emphasize extensive local community involvement and participation.

SAMHSA/CSAT is committed to enhancing or expanding substance abuse treatment programs to provide comprehensive, integrated services that are competent and professional and which effectively meet the critical issues of substance abuse, HIV/AIDS and infectious diseases in these targeted communities. Such services must reflect state-of-the-art treatment practices which appropriately address gender, age, racial, ethnic, cultural, and sexual orientation issues, as well as physical/cognitive disabilities, and related factors such as geographic and economic environments. Additionally, SAMHSA believes that families and consumers contribute significantly to successful outcomes and must be involved in the conceptualization, planning, implementation, and evaluation (including interpretations of results) of SAMHSA projects. Therefore, SAMHSA is committed to funding those projects that are community-based, culturally competent, gender specific, age appropriate and customer driven (family and consumer) in their approaches.

Applicants must have an existing substance abuse treatment program and an existing facility, with demonstrated linkages to members of the target population, community organizations, and relevant institutions. Funds may be requested for the following: 1) to expand organizational capacity to provide a more comprehensive array of community based services through well defined linkages to other organizations/providers; 2) to expand the program's capacity by increasing the number of slots in a residential (not inpatient hospitalization), day treatment, or outpatient substance abuse treatment program, or by adding a new component (outpatient/continuing care) to an existing program; 3) to expand a core program to accommodate clients who are HIV positive or have AIDS; and 4) to enhance accessibility of existing HIV/AIDS, STDs, TB, and hepatitis B and C services by adding community health education and risk reduction programming, outreach services, mobile HIV, STD, TB,

and hepatitis B and C services including counseling/testing capabilities.

The proposed services must be based on science-based theory and objective/empirical evidence of effectiveness. Further, the project's plan must be designed to impact significantly the identified gaps in substance abuse treatment and HIV/AIDS services during the three-year grant period. The applicant must also provide a detailed plan to sustain and continue the project beyond the duration of grant support. Finally, the proposed services should be consistent with and fit within the community's overall response to substance abuse and related HIV/AIDS health issues.

One of the primary goals of CSAT is to improve the health of substance abusers by forging linkages with primary health care, HIV/AIDS, and mental health service providers. This goal is especially critical given the rise in the HIV infection rate among hard to reach, high risk, injecting drug users (IDUs) and their sex and drug sharing partners and is predicated on the following observations: 1) retention in and duration of substance abuse treatment, in its various modalities and delivery systems, is demonstrably effective in protecting substance abusers from HIV (Metzger, Navaline and Woody, 1998); 2) substance abuse treatment is most successful when it includes a comprehensive assessment of each individual's physical and mental health and social needs; and 3) effective substance abuse treatment is best delivered in a sustained continuum that emphasizes the importance of comprehensive primary care, mental health and social services in a community-based environment.

African Americans and Hispanic/Latinos are disproportionately over-represented among AIDS cases (CDC, 1999). This disproportionate representation, while generally considered to be attributed to substantially higher rates of substance abuse and STDs, also closely parallels other health problems, such as cancer, cardiovascular disease and diabetes. On the basis of current information reported by SAMHSA, the evidence underscores the existence of significant and continuing disparities in availability and access to services for African American and Hispanic/Latino substance abusers.

As of June 1999, 711,344 cases of AIDS and 420,201 deaths due to AIDS have been reported to the Centers for Disease Control

and Prevention (CDC) since 1981 (CDC, 1999), and an estimated 650,000 to 900,000 people are living with HIV infection in the United States (Karon et al., 1996). Based on 1999 AIDS surveillance data, there were 311,375 cases of AIDS reported among Whites who represent 73 percent of the total U.S. population but only 43 percent of the total AIDS cases. Racial and ethnic minority populations comprise only 25 percent of the total U.S. population, yet, they represent 56.1 percent of the cumulative AIDS cases and 67 percent of AIDS cases reported in the 12 month period ending June 30, 1999. Moreover, the two population groups, African Americans and Hispanic/Latinos, accounted for 77 percent of the cases in women, 78 percent of the heterosexual cases and 81.5 percent of the pediatric cases (CDC, 1999).

The midyear AIDS surveillance as of June 1999 indicates that injecting drug use (IDU) and sexual contact with an IDU were the major sources of exposure to HIV infection for all racial/ethnic minority populations, especially for African Americans and Hispanic/Latinos. Cumulative AIDS cases as of June 1999 where injecting drug use was a risk factor (this includes the following risk exposure groups--injecting drug users; men who have sex with men and inject drugs; and sex with an IDU) accounted for a 44.8 and 44.1 percent of total AIDS cases among African Americans and Hispanic/Latinos. Among African American and Hispanic/Latino women injecting drug use accounted for 57.8 and 62.7 percent of total cases of AIDS. Finally, among children 13 years of age or less, maternal drug use or sex with an injecting drug user accounted for 51 and 61.3 percent of total pediatric AIDS cases for African Americans and Hispanic/Latinos.

Substance abuse has been the primary source of AIDS for African Americans and Hispanic/Latinos, and for women and children over the course of the epidemic. Over the past few years, AIDS cases by ethnicity have shown a remarkable shift. The number of new AIDS cases each year has been falling for Caucasians and increasing sharply for African Americans and, to a lesser degree, for Hispanic/Latinos (Ward and Duchin, 1997-1998). In 1995, for the first time, the number of new AIDS cases among African Americans exceeded the number of new cases among Caucasians. In that year, the annual rate of AIDS cases per 100,000 population was 119.7 for African Americans, 61.9 for Hispanic/Latinos, and 18.5 for Caucasians. In 1999, the number of new AIDS cases among African Americans continued to be higher than for Caucasians. The annual AIDS case rates

per 100,000 population were 86.3 for African Americans, 39.1 for Hispanic/Latinos, and 9.9 for Caucasians.

Many African Americans, Hispanic/Latinos and/or other racial/ethnic minorities live in large metropolitan statistical areas (MSAs) that are typified by high rates of drug trafficking, unemployment, poverty, and racism. These factors not only contribute to the malaise that permeates these communities, but are as well the underlying causal factors that affect rates of addiction and HIV (National Commission on AIDS, 1994). Moreover, it is within these community settings where HIV/AIDS is most prevalent and where these social conditions have also led to high rates of incarceration, sex work, and homelessness. Criminal justice data indicate drug offenses account for the highest number of Federal crimes for which people are incarcerated (Polonsky et al., 1994). Not surprisingly, these individuals also have high rates of HIV infection (Stryker, 1993). Sex workers, the homeless, and substance abusers are likely to be more concerned with immediate needs such as housing, food, or securing drugs than with the prevention or treatment of their substance abuse or risk of exposure to HIV (Kail et. al., 1995). HIV is also a major co-factor that exacerbates the treatment of the homeless, physically/cognitively disabled, or marginally housed who also may be dually diagnosed with substance abuse and mental illness (St. Lawrence and Brasfield, 1995).

Substance abuse patterns vary greatly regionally and locally across the United States. This fact, coupled with significant differences between available treatment capacity and local or regional demand, often impedes the timely and appropriate response to changing needs. The National Household Survey on Drug Abuse (NHSDA) data indicate increases in substance abuse indices for specific populations, especially for African Americans, Hispanic/Latinos and/or other racial/ethnic minorities, and the need for expanded treatment resources in many geographic areas (SAMHSA, 1996).

Target Population

The target populations for this GFA are African American, Hispanic/Latino and/or other racial/ethnic minority substance abusers including those who may be HIV positive and their significant others in communities highly affected by substance

abuse and HIV/AIDS. Programs may be designed for women and women and their children, adolescents, injecting drug users including men who have sex with men (MSM) and inject drugs, and/or men or women who have been released from prisons and jails. Adolescents, for purpose of this announcement, are individuals who are at least 12 years of age and no older than 22 years of age.

Program Plan

Goal

The primary goal of this program is to reduce the spread of substance abuse related HIV/AIDS and infectious diseases in African American, Hispanic/Latino and other racial/ethnic minority communities by addressing gaps in treatment capacity and access, and by expanding or enhancing the core capabilities of substance abuse treatment programs to provide effective services for their clients and/or their families with specific needs attributed to HIV/AIDS, STDs, TB, or hepatitis B and C.

SAMHSA/CSAT is most interested in applications that demonstrate a comprehensive, integrated, creative and community-based response to a targeted, well documented substance abuse and HIV/AIDS treatment need/problem. SAMHSA/CSAT believes that the accomplishment of this goal requires that applications be submitted by organizations that have 1) demonstrated ties to the grassroots/community-based organizations that are deeply rooted in the culture of the targeted community, and 2) have demonstrated experience in providing culturally appropriate services to the targeted communities.

Design

Identification and Documentation of Targeted Treatment Needs

Applicants are expected to describe fully the targeted treatment need and provide substantial documentation of the extent of the need. In addition, applicants should describe the geographic area and the population characteristics of the areas that will be targeted for the proposed services.

Documentation may be derived from a variety of qualitative and quantitative sources including CDC's surveillance reports, national trend data such as the National Household Survey on Drug Abuse, State data such as that available through State Needs Assessments and from locally generated data or trend analyses. Applicants must also provide a description of currently available resources and a justification for why they are insufficient or inappropriate to respond to the increased demand for treatment services.

Applicants who wish to identify and respond to more than one treatment capacity problem must submit a separate application for each identified issue. However, if the applicant can appropriately treat different target populations using the same substance abuse treatment services, a single application may be submitted.

Intervention Strategy

Applicants are required to demonstrate familiarity with state-of-the-art practices in the area of substance abuse treatment and HIV/AIDS prevention and treatment as it affects the target populations. Applicants must include a detailed description of the methods and approaches that will be used to reach the specified target population(s) of high risk substance abusers, their sex partners, and substance abusing people living with AIDS who are not currently enrolled in a formal substance abuse treatment program. If a program is to be expanded, the applicant must fully describe the existing program, then provide evidence that the expanded component is or can be expected to be (on the basis of scientifically based theory) effective in meeting the defined need. The applicant must also provide evidence that the proposed expansion will address the overall goals and objectives of this program within the three-year grant period. In addition, applicants must provide evidence that the program can provide substance abuse treatment and HIV/AIDS services at costs comparable to local or prevailing costs.

Applicants should describe how the proposed program will be embedded within a comprehensive, integrated, creative and community-based response to issues fueled by substance abuse and HIV/AIDS. Examples of such responses include, but are not limited to: community focused educational and preventive efforts; school based activities such as after school programs; private industry supported work placements for

recovering persons; faith based organizational support; support for the homeless; HIV/AIDS community-based outreach projects to provide HIV counseling and testing services; health education and risk reduction information; access and referrals to STD and TB testing; substance abuse treatment, primary care, mental health and medical services for those who are HIV positive, have AIDS or are at high risk of becoming HIV infected; and involvement of ethnocentric community resource centers. The integration of disparate human services that, in fact, focus on the same populations is also seen as a possible component of a strategic intervention. The applicant will identify the role of these participants in responding to the targeted need. Letters of support (outlining services to be provided, level and intensity of resources committed) from participating and coordinating organizations should be included in Appendix 2 entitled, "Letters of Coordination/Support." Applicants are encouraged to demonstrate planning and coordination of services at the local level with the SSA, and, where applicable, the Centers for Disease Control and Prevention (CDC) HIV Prevention Community Planning Groups, HIV/AIDS CDC funded projects, NIDA funded HIV/AIDS Outreach Cooperative Agreement projects, Health Resources and Services Administration (HRSA) Ryan White Planning Councils, and the Housing Opportunities for People with AIDS (HOPWA), Housing and Urban Development (HUD).

Measures/Parameters/Indicators/Methodology and/or Evaluation

The application must include clear, quantitative goals and objectives for the grant period and present a sound and feasible evaluation plan for documenting that the grantee has met the goals and objectives set in the application. At a minimum, quantitative objectives should be set for the number of individuals served with grant funds, the types and numbers of specific services provided, the outcomes to be achieved by the individuals served, and the applicant's overall progress in reducing substance abuse, HIV/AIDS, STDs, TB, and hepatitis B and C, and related health issues in the targeted community or area (for example, the applicant's progress in addressing the impact of HIV/AIDS and substance abuse on the targeted community's problem).

The Government Performance and Results Act (GPRA) mandates increased accountability and performance-based management by Federal agencies. This has resulted in greater focus on

results or outcomes in evaluating effectiveness of Federal activities, and in measuring progress toward achieving national goals and objectives. CSAT's standard outcome requirements are:

Adults: Percent of service recipients employed, permanently housed in community; with no/reduced involvement with criminal justice system; with no/reduced alcohol or illegal drug consequences; and with no past month substance abuse.

Adolescents: Percent of adolescents who either are service recipients or are children of adult service recipients who are attending school; in stable living environments; have no/reduced involvement in juvenile justice system, have no past month use of alcohol or illegal drugs; and have no/reduced alcohol or illegal drug consequences.

Applicants must demonstrate how the evaluation will demonstrate effectiveness of proposed interventions in achieving these goals. Applicants must clearly state when, because of the target population to be served or the type of services to be provided, one or more goal is inappropriate and will not be addressed.

In tracking outcomes, the evaluation plan must address the following:

1) **Treatment Effectiveness, Including Indicators For:**

- health status (physical and mental health)
- self-sufficiency including employment, legal income, and public assistance status
- social support and functioning, including family and social relationships, living arrangements, and legal status
- alcohol and drug use

2) **Treatment Efficiency, Including:**

- utilization

! retention

! completion

Grantees are expected to comply with GPRA including but not limited to the collection of SAMHSA's Core Client Outcomes. Grantees in their application should state the procedures that they will put in place to ensure compliance with GPRA and the collection of CSAT GPRA Core Client Outcomes (see Appendix D). For a more detailed description of CSAT's GPRA strategy see Appendix C.

The evaluation plan must describe the approaches that will be used to collect and report these data to SAMHSA as part of the annual progress report. A cross-site evaluation will be conducted by a CSAT contractor to support the GPRA requirements. Data collection points will be at baseline/intake, 6-months, and 1-year follow-up. Applicants must agree to participate in all technical assistance and training activities designed to support this initiative and must budget for participation in the cross-site evaluation in addition to their local evaluation. CSAT will provide grantees with quarterly and annual reporting formats that specify the minimum information that is required.

CSAT has available a variety of evaluation tools that grantees may find useful in developing, or augmenting, their existing capacity to collect the types of data that will be required. Post award support will be provided to the grantees through the provision of clinical and programmatic technical assistance, assistance with data collection, reporting, analysis and publication, and assistance with evaluating the impact of expanded new services as well as the community based strategic initiative.

Section III - PROJECT REQUIREMENTS

Project Summary: In 5 lines or fewer, 72 characters per line, applicants must provide a summary for later use in publications, reporting to Congress, press releases, etc., should the application be funded. This may be the first 5 lines of the Project Abstract.

Content of Application Requirements

All applicants must provide the information specified below under the proper section heading. The information requested relates to the individual review criteria in Section IV of the GFA.

A. Project Description with Supporting Documentation

- Describe the nature of the problem and extent of the need (based on local data) in terms of the goals of this GFA.

- Define the target population and provide justification for any exclusions under SAMHSA's Population Inclusion Requirement (See Part II).

- Document the inability to respond to the need with existing treatment resources and HIV/AIDS services, and the potential impact if the problem is not resolved.

- Clearly state the purpose of the proposed project, with goals and objectives. Describe how achievement of goals will support meaningful and relevant results and expand capacity.

B. Project Plan

- Describe and justify the design chosen for the proposed project.

- Describe the treatment component and HIV/AIDS services to be expanded or enhanced and document that it demonstrates best practices based on research and clinical literature or successful outcomes based on local outcome data. This explanation should include data on current capacity, average length of treatment, retention rates, and outcomes. It should also address age, race/ethnic, cultural, language, sexual orientation, disability, literacy and gender issues and how the treatment component will handle these issues relative to the target population.

- For those data sources that are not well known, provide enough information on how the data were collected so that the reliability and validity of the data can be assessed.

- Provide quantitative goals and objectives for the treatment component and HIV/AIDS services in terms of the numbers of individuals to be served, types and numbers of services to be provided, and outcomes to be achieved. Describe how the targeted population will be identified, recruited into treatment, and retained in treatment. A description of current referral arrangements and proposed amendments to them will support this aspect of the narrative.

- Describe how individuals reflective of the target population were involved in the preparation of the application and will be involved in planning, implementation, and data interpretation of the project.

- Describe how the treatment component will be embedded within the existing community-based response to substance abuse problems. This should include what roles other community organizations will have in the overall, integrated effort.

C. Evaluation/Methodology

- Present a plan for collecting, analyzing, and reporting the information required to document that the grantee's goals and objectives have been reached. This should include a description of the treatment provider's existing approach to the collection of client, service use, and outcome data and how that will be modified to meet the requirements described in this GFA.

- Document the appropriateness of the proposed outcome measures for the target population. This should address not only traditional reliability and validity but also sensitivity to age, gender, sexual orientation, and racial/ethnic characteristics of the target population.

- Describe how adherence/fidelity to implementation of the model will be achieved, and how results will be assessed.

- Describe strategies for data management, data processing and clean-up, quality control and data retention.

- Discuss the extent to which the target population will be involved in the interpretation of findings.

- Describe plans for reporting and disseminating the project's findings.

- Discuss the extent to which the program can supply necessary GPRA data for information on implementation and validity of results.

D. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support

- Present a management plan for the project that describes the organizations that will be involved in the project; presents their roles in the project; and addresses their relevant experience.

- Describe time lines for the plan.

- Discuss how the proposed plan is achievable and realistic.

- Discuss the capability and experience of the applicant organization with similar projects and populations.

- Discuss linkages/collaborations with other organizations including other non-profit groups, universities, clinics, the Centers for Disease Control and Prevention (CDC) HIV Prevention Community Planning Groups, HIV/AIDS CDC funded projects, NIDA funded HIV/AIDS Outreach Cooperative Agreement projects, Health Resources and Services Administration (HRSA)

Ryan White Planning Councils, and the Housing Opportunities for People with AIDS (HOPWA), in the Department of Housing and Urban Development (HUD).

- Provide a staffing plan, including the level of effort and qualifications of the Project Director and other key personnel including the clinical, substance abuse and HIV/AIDS, and support personnel within the treatment component.

- Describe the resources available (e.g., facilities, equipment), and provide evidence that services will be provided in a location/facility that is adequate and accessible and that the environment is conducive to the target population.

- Show evidence of the appropriateness of the proposed staff to the language, age, gender, sexual orientation and ethnic/racial/cultural factors of the target population.

- Provide evidence that the proposed staff have requisite training, experience, and sensitivity to provide treatment/services to African American, Hispanic/Latino and/or other racial/ethnic minority populations.

- Provide evidence that required resources not included in this Federal budget request are adequate and accessible.

- Provide a plan to secure resources or obtain support to continue services after the grant project period has ended.

Post Award Requirements

Grantees will be required to attend (and, thus, must budget for) two technical assistance meetings in the first year of the grant, and two meetings in each of the remaining years. A minimum of two persons (Program Director and the Program Evaluator) are expected to attend.

Section IV - REVIEW OF APPLICATIONS

Guidelines

Applications submitted in response to this GFA will be reviewed for scientific/technical merit in accordance with established PHS/SAMHSA review procedures outlined in the Review Process section of Part II. Applicants must review the Special Considerations/Requirements and Application Procedures sections that follow, as well as the guidance provided in Part II, before completing the application.

The review criteria A-D below correspond to subsections A-D in Section III above to assist in the application process. Reviewers will respond to each review criterion on the basis of the information provided in Section III by the applicants. Therefore, it is important for applicants to follow carefully the outline, headings, and subheadings when providing the requested information.

Applications will be reviewed and evaluated according to the review criteria that follow. The points noted for each criterion indicate the maximum number of points the reviewers may assign to that criterion if the application is considered to have sufficient merit for scoring. **The bulleted statements that follow each review criterion do not have weights.** The assigned points will be used to calculate a raw score that will be converted to the official priority score.

Peer reviewers will be instructed to review and evaluate each relevant criterion in relation to cultural competence. Points will be deducted from applications that do not adequately address the cultural aspects of the criteria. (See Appendix D in Part II, for guidelines that will be used to assess cultural competence.)

Review Criteria

A. Adequacy of the Project Description and Justification of Need (30 Points)

! Extent to which the problem and population(s) targeted in this GFA are clearly described.

- Extent to which a need for this project was clearly demonstrated by supportive data that the numbers of chronic, hardcore drug users and their sex partners exceed existing capacity for substance abuse treatment and HIV/AIDS services.

- Extent to which the targeted population is clearly defined and appropriate. If applicable, the extent to which adequate justification for exclusion was demonstrated.

- Adequacy of the evidence that the proposed project will have an impact on the stated problem.

- Adequacy of the description of particular issues related to the target populations.

- Extent to which the applicant demonstrates an understanding of the goals and objectives of the program as defined in this GFA.

- Extent to which the proposed project goals will support meaningful and relevant results.

- Extent to which the achievement of those goals would expand capacity.

B. <u>Project Plan</u> (30 Points)

- Extent to which the proposed design addresses the program's and proposed project's plans and goals.

- Extent to which individuals reflective of the target population are involved in the preparation and planned implementation of the project.

- Extent to which the project plan appropriately addresses age, race/ethnic, cultural, language, sexual orientation, disability, literacy, and gender issues in the proposed design activities such as models, outreach, intervention, and/or services.

- Extent to which the treatment and HIV/AIDS components are integrated with the larger community based response to substance abuse and HIV/AIDS.

- Evidence that the project is likely to contribute to an increase in numbers of clients seeking treatment, or an increase in the numbers of clients who reduce or eliminate risk producing behaviors and/or decrease in the spread of HIV/AIDS, STDs, hepatitis B and C, TB and other related health issues among the target population and their contacts.

- Extent to which the treatment and the HIV/AIDS services components to be enhanced or expanded are based on state-of-the-art literature and practices.

C. Evaluation/Methodology (20 Points)

- Clarity/feasibility/appropriateness of proposed evaluation plan and methodology.

- Appropriateness of the proposed outcome measures in terms of reliability and validity for the target population including sensitivity to age, gender, culture, sexual orientation, and racial/ethnic characteristics of the target population.

- Extent to which the evaluation plan addresses effectiveness and efficiency.

- Quality of the indicators proposed to track the applicant's adherence/fidelity in implementing the identified treatment model and progress in addressing the targeted treatment capacity needs.

- Appropriateness of strategies for data management, data processing and clean-up, quality control, and data retention.

- Extent to which target population is involved in the interpretation of the findings.

- Adequacy of the proposed reporting and dissemination plan of the findings.

- Extent to which the proposed project can supply the necessary agency GPRA data for information on implementation, adherence to intervention design,

validity of results, dissemination of findings and next steps.

D. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support (20 Points)

- Extent to which the proposed management plan implements the project goals and is timely, feasible, achievable, and realistic, as well as culturally appropriate.

- Capability and experience of the applicant organization with similar projects and populations.

- Extent to which there is collaboration with other agencies, organizations and institutions, including non-profit groups, universities, and clinics.

- Evidence of linkages/collaborations with the activities of the Centers for Disease Control and Prevention (CDC) HIV Prevention Community Planning Groups, HIV/AIDS CDC funded projects, NIDA funded HIV/AIDS Outreach Cooperative Agreement projects, Health Resources and Services Administration (HRSA) Ryan White Planning Councils, and the Housing Opportunities for People with AIDS (HOPWA), Housing and Urban Development (HUD).

- Evidence that the proposed staffing pattern is appropriate and adequate for implementation of the project.

- Qualifications and experience of the project director and other key personnel, including the clinical and support personnel within the treatment component and proposed consultants and subcontractors.

- Extent to which the staff’s qualification is reflective of the target population or can demonstrate cultural competence to ensure sensitivity to language, age, gender, race/ethnicity, sexual orientation, and other cultural factors related to the target population.

- Evidence that the proposed staff have requisite training, experience, and sensitivity to provide

treatment/services to African American, Hispanic/Latino and/or other racial/ethnic minority populations.

- Adequacy and availability of resources and equipment.

- Evidence that the activities or services are provided in a location/facility that is adequate and accessible, and the environment is conducive to the population to be served.

- Adequacy of additional resources not included in this Federal budget request but needed to implement this project, if applicable.

- Appropriateness of a plan to secure resources in order to sustain and continue this project beyond the Federal funded program years.

NOTE: Although the reasonableness and appropriateness of the proposed budget for the proposed project are not review criteria for this GFA, the Initial Review Group will be asked to consider these after the merits of the application have been considered.

Section V - SPECIAL CONSIDERATIONS/REQUIREMENTS

SAMHSA's policies and special considerations/requirements related to this program include:

- Population Inclusion Requirement
- Government Performance Monitoring
- Healthy People 2000: The Health People 2000 priority areas related to this program are: Alcohol and Other Drugs (Chapter 4), HIV/AIDS Infection (Chapter 18), and Mental Health (Chapter 6).
- Consumer Bill of Rights
- Promoting Nonuse of Tobacco
- Supplantation of Existing Funds (include documentation in Appendix 3)
- Letter of Intent
- Single State Agency Coordination (include documentation in Appendix 4)
- Intergovernmental Review
- Public Health System Reporting Requirements

- Confidentiality/SAMHSA Participant Protection (The SAMHSA Center for Substance Abuse Treatment Director has determined that projects funded under the program must meet SAMHSA Participant Protection requirements.)

Specific guidance and requirements for the application related to these policies and special considerations/requirements can be found in Part II in the section by the same name.

Section VI - APPLICATION PROCEDURES

All applicants must use application form PHS 5161-1 (Rev. 6/99), which contains Standard Form 424 (face page). Type one of the following in Item Number 10 on the face page of the application form:

TI 00-005 TCE/HIV - A (for applicants serving substance abusing African American, Hispanic/Latino and/or other racial/ethnic minority women and women and their children)

TI 00-005 TCE/HIV - B (for applicants serving substance abusing African American, Hispanic/Latino and/or other racial/ethnic minority adolescents)

TI 00-005 TCE/HIV - C (for applicants serving substance abusing African American, Hispanic/Latino and/or other racial/ethnic minority injecting drug users including men who have sex with men and inject drugs (MSM)

TI 00-005 TCE/HIV - D (for applicants serving substance abusing African American, Hispanic/Latino and/or other racial/ethnic minority men or women who have been released from prisons and jails)

For more specific information on where to obtain application materials and guidelines, see Application Procedures section in Part II.

Complete applications and all appendices must be sent to the following address:

SAMHSA Programs
Center for Scientific Review

National Institutes of Health
Suite 1040
6701 ROCKLEDGE DRIVE MSC-7710
BETHESDA, MD 20892-7710 *

*Applicants who wish to use express mail or courier service should change the zip code to 20817.

Complete application kits for this program may be obtained from the National Clearinghouse for Alcohol and Drug Information (NCADI), phone number: 800-729-6686. The address for NCADI is provided in Part II.

Application Receipt And Review Schedule

The schedule for receipt and review of applications under this GFA is as follows:

Receipt Date	IRG Review	Council Review	Earliest Start Date
June 13, 2000	Jul/Aug 2000	Sept 2000	Sept 2000

Applications must be received by the above receipt date(s) to be accepted for review. An application received after the deadline may be acceptable if it carries a legible proof-of-mailing date assigned by the carrier and the proof-of-mailing date is not later than one week prior to the deadline date. Private metered postmarks are not acceptable as proof of timely mailing. (NOTE: These instructions replace the “Late Applications” instructions found in the PHS 5161-1).

Consequences of Late Submission

Applications received after the above receipt date will not be accepted and will be returned to the applicant without review.

Application Requirements/Component Checklist

All applicants must use the Public Health Service (PHS) Grant Application form 5161-1 (Rev. 6/99) and follow the requirements and guidelines for developing an application

presented in Part I-Programmatic Guidance and Part II-General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements.

The application should provide a comprehensive framework and description of all aspects of the proposed project. It should be written in a manner that is self-explanatory to reviewers unfamiliar with the prior related activities of the applicant. It should be succinct and well organized, should use section labels that match those provided in the table of contents for the Program Narrative that follows, and must contain all the information necessary for reviewers to understand the proposed project.

To ensure that sufficient information is included for the technical merit review of the application, the Program Narrative section of application must address, but is not limited to, issues raised in the sections of this document entitled:

1. Program Description
2. Project Requirements
3. Review of Applications

Note: It is requested that on a separate sheet of paper the name, title, and organization affiliation of the individual who is primarily responsible for writing the application be provided. Providing this information is voluntary and will in no way be used to influence the acceptance or review of the application. When submitting the information, please insert the completed sheet behind the application face page.

A **COMPLETE** application consists of the following components **IN THE ORDER SPECIFIED BELOW**. A description of each of these components can be found in Part II.

_____FACE PAGE FOR THE PHS 5161-1 (Standard Form 424 - See Appendix A in Part II for instructions.)

_____OPTIONAL INFORMATION ON APPLICATION WRITER (See note above)

_____ABSTRACT (not to exceed 35 lines)

_____TABLE OF CONTENTS (include page numbers for each of the major sections of the Program Narrative, as well as for each appendix)

_____BUDGET FORM (Standard Form 424A - See Appendix B in Part II for instructions.)

_____PROGRAM NARRATIVE (The information requested for sections A-D of the Program Narrative is discussed in the subsections with similar titles in Section III, Project Requirements, and in Section IV, Review of Applications. **Sections A-D may not exceed 25 single-spaced pages. Applications exceeding these page limits will not be accepted for review and will be returned to the applicant.**)

_____A. Project Description/Justification of Need
_____B. Project Plan
_____C. Evaluation/Methodology
_____D. Project Management: Implementation Plan, Organization, Staff, Equipment/Facilities, and Other Support

There are no page limits for the following sections E-H except as noted in G. Biographical Sketches/Job Descriptions. Sections E-H will not be counted toward the 25 page limitation for sections A-D.

_____E. Literature Citations (This section must contain complete citations, including titles and all authors, for literature cited in the application.)

_____F. Budget Justification/Existing Resources/Other Support

_____Sections B, C, and E of the Standard Form 424A must be filled out according the instructions in Part II, Appendix B.

_____A line item budget and specific justification in narrative form for the first project year's direct costs AND for each future year must be provided. For contractual costs, provide a similar

yearly breakdown and justification for ALL costs (including overhead or indirect costs.

_____All other resources needed to accomplish the project for the life of the grant (e.g., staff, funds, equipment, office space) and evidence that the project will have access to these, either through the grant or, as appropriate, through other resources, must be specified.

Other Support (Other Support refers to all current or pending support related to this application. Applicant organizations are reminded of the necessity to provide full and reliable information regarding "other support," i.e., all Federal and non-Federal active or pending support. Applicants should be cognizant that serious consequences could result if failure to provide complete and accurate information is construed as misleading to the PHS and could, therefore, lead to delay in the processing of the application. In signing the face page of the application, the authorized representative of the applicant organization certifies that the application information is accurate and complete.

For your organization and key organizations that are collaborating with you in this proposed project, list all currently active support and any applications/proposals pending review or funding that relate to the project. If there are none, state "none." For all active and pending support listed, also provide the following information:

1. Source of support (including identifying number and title).
2. Dates of entire project period.
3. Annual direct costs supported/requested.
4. Brief description of the project.
5. Whether project overlaps, duplicates, or is being supplemented by the present application; delineate and justify the nature and extent of any programmatic and/or budgetary overlaps.

_____G. Biographical Sketches/Job Descriptions
A biographical sketch must be included for the project director and for other key positions. Each of the

biographical sketches must not exceed **2 pages** in length. In the event that a biographical sketch is included for an individual not yet hired, a letter of commitment from that person must be included with his/her biographical sketch. Job descriptions for key personnel must not exceed **1 page** in length. The suggested contents for biographical sketches and job descriptions are listed in Item 6 in the Program Narrative section of the PHS 5161-1.

_____H. Confidentiality/SAMHSA Participant Protection The information provided in this section will be used to determine whether the level of protection of participants appears adequate or whether further provisions are needed, according to SAMHSA Participant Protection (SPP) standards. Adequate protection of participants is an essential part of an application and will be considered in funding decisions.

Projects proposed under this announcement may expose participants to risks in as many ways as projects can differ from each other. Following are some examples, but they do not exhaust the possibilities. Applicants should report in this section any foreseeable risks for project participants, and the procedures developed to protect participants from those risks, as set forth below. Applicants should discuss how each element will be addressed, or why it does not apply to the project.

Note: So that the adequacy of plans to address protection of participants, confidentiality, and other ethical concerns can be evaluated, the information requested below, which may appear in other sections of the narrative, should be included in this section of the application as well.

1. Protection from Potential Risks:

(a) Identify and describe any foreseeable physical, medical, psychological, social, legal, or other risks or adverse effects, besides the confidentiality issues addressed below, which are due either to participation in the project itself, or to the evaluation activities.

(b) Where appropriate, describe alternative treatments and procedures that might be advantageous to the subjects and the rationale for their nonuser.

(c) Describe the procedures that will be followed to minimize or protect participants against potential risks, including risks to confidentiality.

(d) Where appropriate, specify plans to provide needed professional intervention in the event of adverse effects to participants.

2. Equitable selection of participants:

Target population(s):

Describe the sociodemographic characteristics of the target population(s) for the proposed project, including age, gender, racial/ethnic composition, and other distinguishing characteristics (e.g., homeless youth, foster children, children of substance abusers, pregnant women, institutionalized individuals, or other special population groups).

Recruitment and Selection:

(a) Specify the criteria for inclusion or exclusion of participants and explain the rationale for these criteria.

(b) Explain the rationale for the use of special classes of subjects, such a pregnant women, children, institutionalized mentally disabled, prisoners, or others who are likely to be vulnerable.

(c) Summarize the recruitment and selection procedures, including the circumstances under which participation will be sought and who will seek it.

3. Absence of Coercion:

(a) Explain whether participation in the project is voluntary or mandatory. Identify any potentially coercive elements that may be present (e.g., court

orders mandating individuals to participate in a particular intervention or treatment program).

(b) If participants are paid or awarded gifts for involvement, explain the remuneration process.

(c) Clarify how it will be explained to volunteer participants that their involvement in the study is not related to services and the remuneration will be given even if they do not complete the study.

4. Appropriate Data Collection:

(a) Identify from whom data will be collected (e.g., participants themselves, family members, teachers, others) and by what means or sources (e.g., school records, personal interviews, written questionnaires, psychological assessment instruments, observation).

(b) Identify the form of specimens (e.g., urine, blood), records, or data. Indicate whether the material or data will be obtained specifically for evaluative/research purposes or whether use will be made of existing specimens, records, or data. Also, where appropriate, describe the provisions for monitoring the data to ensure the safety of subjects.

(c) Provide, in Appendix No. 5 entitled "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that will be used or proposed to be used in the case of cooperative agreements.

5. Privacy and Confidentiality:

Specify the procedures that will be implemented to ensure privacy and confidentiality, including by whom and how data will be collected, procedures for administration of data collection instruments, where data will be stored, who will/will not have access to information, and how the identity of participants will be safeguarded (e.g., through the use of a coding system on data records; limiting access to records; storing identifiers separately from data).

Note: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2).

6. Adequate Consent Procedures:

(a) Specify what information will be provided to participants regarding the nature and purpose of their participation; the voluntary nature of their participation; their right to withdraw from the project at any time, without prejudice; anticipated use of data; procedures for maintaining confidentiality of the data; potential risks; and procedures that will be implemented to protect participants against these risks.

(b) Explain how consent will be appropriately secured for youth, elderly, low literacy and/or for those whose first language is not English.

Note: If the project poses potential physical, medical, psychological, legal, social, or other risks, awardees may be required to obtain written informed consent.

(c) Indicate whether it is planned to obtain informed consent from participants and/or their parents or legal guardians, and describe the method of documenting consent. For example: Are consent forms read to individuals? Are prospective participants questioned to ensure they understand the forms? Are they given copies of what they sign?

Copies of sample (blank) consent forms should be included in Appendix No. 6 entitled "Sample Consent Forms." If appropriate, provide English translations.

Note: In obtaining consent, no wording should be used that implies that the participant waives or appears to waive any legal rights, is not free to terminate involvement with the project, or releases the institution or its agents from liability for negligence.

(d) Indicate whether separate consents will be obtained for different stages or aspects of the project, and whether consent for the collection of evaluative data will be required for participation in the project itself. For example, will separate consent be obtained for the collection of evaluation data in addition to the consent obtained for participation in the intervention, treatment, or services project itself? Will individuals not consenting to the collection of individually identifiable data for evaluative purposes be permitted to participate in the project?

7. Risk/Benefit Discussion:

Discuss why the risks to subjects are reasonable in relation to the anticipated benefits to subjects and in relation to the importance of the knowledge that may reasonably be expected to result.

_____APPENDICES (Only the appendices specified below may be included in the application. These appendices must not be used to extend or replace any of the required sections of the Program Narrative. The total number of pages in the appendices **CANNOT EXCEED 30 PAGES,** excluding all instruments.)

Appendix 1: Certification of Experience/Licensure/Accreditation
Appendix 2: Letters of Coordination/Support
Appendix 3: Non-supplantation of Funds Letter
Appendix 4: Letters to SSA(s)
Appendix 5: Data Collection Instruments/Interview Protocols
Appendix 6: Sample Consent Forms

_____ASSURANCES NON-CONSTRUCTION PROGRAMS (STANDARD FORM 424B)

_____CERTIFICATIONS

_____DISCLOSURE OF LOBBYING ACTIVITIES

_____CHECKLIST PAGE (See Appendix C in Part II for instructions)

Terms and Conditions of Support

For specific guidelines on terms and conditions of support, allowable items of expenditure and alterations and renovations, applicants must refer to sections in Part II by the same names. In addition, in accepting the award the Grantee agrees to provide SAMHSA with GPRA Client Outcome and Evaluation Data.

Reporting Requirements

For the SAMHSA policy and requirements related to reporting, applicants must refer to the Reporting Requirements section in Part II.

Lobbying Prohibitions

SAMHSA's policy on lobbying prohibitions is applicable to this program; therefore, applicants must refer to the section in Part II by the same name.

Award Decision Criteria

Applications will be considered for funding on the basis of their overall technical merit as determined through the IRG and the CSAT National Advisory Council review process. Other award criteria will include:

- Availability of funds.
- Distribution of awards in terms of: geography, target population, and program size.
- Evidence of non-supplantation of funds.
- Applications that target unserved populations in the MSA or State.

Contacts for Additional Information

Questions on program issues may be directed to:

Lisa A. Manley
Treatment and Systems Improvement Branch
Division of Practice and Systems Development

Center for Substance Abuse Treatment, SAMHSA
Rockwall II, 7th Floor
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2297

Questions on grants management issues may be directed to:

Christine Chen
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
Rockwall II, 6th Floor
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-8926

APPENDIX A
Eligible States

Eligible States with Annual AIDS Rates >10 Cases per 100,000 Populations

State	Annual AIDS Case Rates 1998
Alabama	14.7
Arizona	15.8
California	17.6
Connecticut	19.0
Delaware	23.8
District of Columbia	143.3
Florida	38.1
Georgia	21.4
Hawaii	11.7
Illinois	10.7
Louisiana	20.7
Maryland	31.8
Massachusetts	20.3
Mississippi	15.7
Nevada	14.7
New Jersey	25.4
New York	42.1
North Carolina	10.5
Pennsylvania	15.0
Rhode Island	12.1

South Carolina	25.7
Tennessee	14.2
Texas	18.8
Virginia	13.4
Puerto Rico	37.5
Virgin Islands	27.9

Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 1999: 11(no. 1).

Appendix A
(Continued)
Eligible MSAs

Eligible Metropolitan Areas with Annual AIDS Rates > 15 Cases per 100,000

City, State	**Annual AIDS Case Rates 1998**
Atlanta, GA	29.4
Austin, TX	23.6
Baltimore, MD	47.1
Baton Rouge, LA	33.6
Bergen-Passaic, NJ	19.9
Birmingham, AL	16.7
Boston, MA	19.1
Charleston, SC	21.4
Columbia, SC	47.2
Dallas, TX	21.0
El Paso, TX	14.8
Fort Lauderdale, FL	65.8
Greenville, SC	16.1
Harrisburg, PA	16.9
Hartford, CT	22.2
Houston, TX	34.1
Jacksonville, FL	26.8
Jersey City, NJ	44.0
Las Vegas, NV	17.3
Los Angeles, CA	22.0

Louisville, KY	17.5
Memphis, TN	31.9
Miami, FL	72.5
Nashville, TN	18.2
New Haven, CT	20.1
New Orleans, LA	33.8
New York, NY	74.9
Newark, NJ	49.3
Norfolk, VA	18.2
Oakland, CA	17.7
Orlando, FL	33.6
Philadelphia, PA	28.1
Phoenix, AZ	19.3
Richmond, VA	21.7
Rochester, NY	15.3
San Diego, CA	20.3
San Francisco, CA	53.7
San Juan, PR	48.4
Sarasota, FL	17.3
Springfield, MA	18.7
Tampa-Saint Petersburg, FL	25.5
Washington, DC	28.1
West Palm Beach, FL	45.3
Wilmington, DE	24.0

Source: Centers for Disease Control and Prevention.
HIV/AIDS Surveillance Report, 1999 11(No.1).

APPENDIX B
REFERENCES

Centers for Disease Control and Prevention (1999). HIV/AIDS Surveillance Report 11 (No.1) Atlanta, GA: CDC.

National Commission on AIDS, Annual Report, (1994).

Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Population Estimates 1996, (1996).

Kail, B.L., Watson, D.D. & Ray, S., (1995) Needle-using practices within the sex industry: National AIDS Research Consortium. American Journal of Drug and Alcohol Abuse, May, 21(9), 241-255.

Karon , J .M., Rosenberg, P.S., McQuillan, G., Khare, M., Gwinn, M, & Petersen, L. R. (1996). Prevalence of HIV infection in the United States, 1984 to 1992. Journal of the American Medical Association, Jul 10, 276(2), 126-131.

Metzger, D.S., Navaline, H. & Woody, G.E. (1998) Drug abuse treatment as AIDS prevention, Public Health Reports, 113,97-106.

Polansky, S., Kerr, S., Harris, B., Gaiter, J., Fitchner, R.R., & Kennedy, M.G. (1994), HIV prevention in prisons and jails: Obstacles and opportunities, Public Health Reports, Sept.-Oct., 109(5), 615-625.

St. Lawrence, J.S. & Brasfled, T.L. (1995), HIV risk behavior among homeless adults, AIDS Education Prevention. 7(1), 22-31.

Stryker, J. & Bayer, J.R. (1995) Two divisive issues. Journal of the American Medical Association, July 28, 270(4), 494-495.

Ward, J. W. & Duching, J.S. (1997-1998), The epidemiology of HIV and AIDS in the United States, AIDS Clinical Review, 1-45.

APPENDIX C

CSAT's GPRA STRATEGY

OVERVIEW

The Government Performance and Results Act of 1993 (Public Law 103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a three to five year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to "explain" their success and failures based on the performance monitoring data. While the language of the statute talks about separate Annual Performance Plans and Annual Performance Reports, ASMB/HHS has chosen to incorporate the elements of the annual reports into the annual President's Budget and supporting documents. The following provides an overview of how the Center for Substance Abuse Treatment, in conjunction with the Office of the Administrator/SAMHSA, CMHS, and CSAP, are addressing these statutory requirements.

DEFINITIONS

Performance Monitoring	The ongoing measurement and reporting of program accomplishments, particularly progress towards preestablished goals. The monitoring can involve process, output, and outcome measures.
Evaluation	Individual systematic studies conducted periodically or "as needed" to assess how well a program is working and why particular outcomes have (or have not) been achieved.
Program	For GPRA reporting purposes, a set of activities that have a common purpose and for which targets can (will) be established.[1]
Activity	A group of grants, cooperative agreements, and contracts that together are directed toward a common objective.
Project	An individual grant, cooperative agreement, or contract.

CENTER (OR MISSION) GPRA OUTCOMES

[1]GPRA gives agencies broad discretion with respect to how its statutory programs are aggregated or disaggregated for GPRA reporting purposes.

The mission of the Center for Substance Abuse Treatment is to support and improve the effectiveness and efficiency of substance abuse treatment services throughout the United States. However, it is not the only agency in the Federal government that has substance abuse treatment as part of its mission. The Health Care Financing Administration, Department of Veterans Affairs, and the Department of Justice all provide considerable support to substance abuse treatment. It shares with these agencies responsibility for achieving the objectives and targets for Goal 3 of the Office of National Drug Control Policy's Performance Measures of Effectiveness:

Reduce the Health and Social Costs Associated with Drug Use.

Objective 1 is to support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse. The individual target areas under this objective include reducing the treatment gap (Goal 3.1.1), demonstrating improved effectiveness for those completing treatment (Goal 3.1.2), reducing waiting time for treatment (Goal 3.1.3), implementing a national treatment outcome monitoring system (Goal 3.1.4), and disseminating treatment information (Goal 3.1.5). Objective 4 is to support and promote the education, training, and credentialing of professionals who work with substance abusers.

CSAT will be working closely with the OAS/SAMHSA, ONDCP, and other Federal demand reduction agencies to develop annual targets and to implement a data collection/information management strategy that will provide the necessary measures to report on an annual basis on progress toward the targets presented in the ONDCP plan. These performance measures will, at an aggregate level, provide a measure of the overall success of CSAT's activities. While it will be extremely difficult to attribute success or failure in meeting ONDCP's goals to individual programs or agencies, CSAT is committed to working with ONDCP on evaluations designed to attempt to disaggregate the effects. With regard to the data necessary to measure progress, the National Household Survey on Drug Abuse (conducted by SAMHSA) is the principal source of data on prevalence of drug abuse and on the treatment gap. Assessing progress on improving effectiveness for those completing treatment requires the implementation of a national treatment outcome monitoring system (Target 3.1.4). ONDCP is funding an effort to develop such a system and it is projected in Performance Measures of Effectiveness to be completed by FY 2002.

Until then, CSAT will rely on more limited data, generated within its own funded grant programs, to provide an indication of the impact that our efforts are having in these particular target areas. It will not be representative of the overall national treatment system, nor of all Federal activities that could affect these outcomes. For example, from its targeted capacity expansion program (funded at the end of FY 1998), CSAT will present baseline data on the numbers of individuals treated, percent completing treatment, percent not using illegal drugs, percent employed, and percent engaged in illegal activity (i.e., measures indicated in the ONDCP targets) in its FY 2001 report with targets for future years. As the efforts to incorporate outcome indicators into the SAPT Block Grant are completed over the next

several years, these will be added to the outcomes reported from the targeted capacity expansion program.

In addition to these "end" outcomes, it is suggested that CSAT consider a routine customer service survey to provide the broadest possible range of customers (and potential customers) with a means of providing feedback on our services and input into future efforts. We would propose an annual survey with a short, structured questionnaire that would also include an unstructured opportunity for respondents to provide additional input if they so choose.

CSATs "PROGRAMS" FOR GPRA REPORTING PURPOSES

All activities in SAMHSA (and, therefore, CSAT) have been divided into four broad areas or "programmatic goals" for GPRA reporting purposes:

- Goal 1: Assure services availability;
- Goal 2: Meet unmet and emerging needs;
- Goal 3: Bridge the gap between research and practice;
- Goal 4: Enhance service system performance[2]

The following table provides the crosswalk between the budget/statutory authorities and the "programs":

	KD&A	TCE	SAPTBG	NDC
Goal 1			X	
Goal 2		X		
Goal 3	X			
Goal 4			X	X

KD - Knowledge Development
KA - Knowledge Application
SAPTBG - Substance Abuse Prevention and Treatment Block Grant
TCE - Targeted Capacity Expansion

NDC - National Data Collection/Data Infrastructure

[2]Goal 4 activities are, essentially, those activities that are funded with Block Grant set-aside dollars for which SAMHSA seeks a distinction in the budget process (i.e., National Data Collection/Data Infrastructure).

For each GPRA [program] goal, a standard set of output and outcome measures across all SAMHSA activities is to be developed that will provide the basis for establishing targets and reporting performance. While some preliminary discussions have been held, at this time there are no agreed upon performance measures or methods for collecting and analyzing the data.[3] In the following sections, CSAT's performance monitoring plans for each of the programmatic areas are presented. It should be understood that they are subject to change as the OA and other Centers enter into discussion and negotiate final measures. In addition, at the end of the document, a preliminary plan for the use of evaluation in conjunction with performance monitoring is presented for discussion purposes.

1. ASSURE SERVICES AVAILABILITY

Into this program goal area fall the major services activities of CSAT: the Substance Abuse Prevention and Treatment Block Grant. In FY 2000 the Block grant application was revised and approved by the Office of Management and Budget to permit the voluntary collection of data from the States. More specifically:

- Number of clients served (unduplicated)

- Increase % of adults receiving services who:
  (a) were currently employed or engaged in productive activities;
  (b) had a permanent place to live in the community;
  (c) had no/reduced involvement with the criminal justice system.

- Percent decrease in
  (a) Alcohol use;
  (b) Marijuana use;
  (c) Cocaine use;
  (d) Amphetamine use
  (e) Opiate use

In addition, in the Fall of 1999 a customer satisfaction survey was designed and approved for collection from each state on the level of satisfaction with Technical Assistance and Needs Assessment Services provided to the States. More specifically:

---

[3]Only measures of client outcomes have been developed and agreed to by each of the Centers. However, these measures are really only appropriate for "services" programs where the provision of treatment is the principal purpose of the activity (i.e., Goals 2 and 3). The client outcome measures will be presented under Goals 2 and 3.

- Increase % of States that express satisfaction with TA provided
- Increase % of TA events that result in systems, program or practice improvements

2. MEET UNMET OR EMERGING NEEDS

Into this program goal area fall the major services activities of CSAT: Targeted Capacity Expansion Grants. Simplistically, the following questions need to be answered about these activities within a performance monitoring context:

- Were identified needs met?
- Was service availability improved?
- Are client outcomes good (e.g., better than benchmarks)?

The client outcome assessment strategy mentioned earlier will provide the data necessary for CSAT to address these questions. The strategy, developed and shared by the three Centers, involves requiring each SAMHSA project that involves services to individuals to collect a uniform set of data elements from each individual at admission to services and 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services increased who:
  a) were currently employed or engaged in productive activities
  b) had a permanent place to live in the community
  c) had reduced involvement with the criminal justice system
  d) had no past month use of illegal drugs or misuse of prescription drugs
  e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs

- Percent of children/adolescents under age 18 receiving services who:
  a) were attending school
  b) were residing in a stable living environment
  c) had no involvement in the juvenile justice system
  d) had no past month use of alcohol or illegal drugs
  e) experienced reduced substance abuse related health, behavior, or social. consequences.

These data, combined with data taken from the initial grant applications, will enable CSAT to address each of the critical success questions.

3. BRIDGE THE GAP BETWEEN RESEARCH AND PRACTICE

This "program" or goal covers that set of activities that are knowledge development/research activities. Initially funded in FY1996, CSAT's portfolio in this area currently includes multi-site grant and cooperative agreement programs, several of which are being conducted in collaboration with one or more of the other two Centers. These activities cover a broad range of substance abuse treatment issues including adult and adolescent treatment, treatments for marijuana and methamphetamine abuse, the impact of managed care on substance abuse treatment, and the persistence of treatment effects. In FY1999, a general program announcement to support knowledge development activity will be added to the CSAT portfolio.

The purpose of conducting knowledge development activities within CSAT is to provide answers to policy-relevant questions or develop cost-effective approaches to organizing or providing substance abuse treatment that can be used by the field. Simplistically then, there are two criteria of success for knowledge development activities:

- Knowledge was developed; and
- The knowledge is potentially useful to the field.

While progress toward these goals can be monitored during the conduct of the activity, only after the research data are collected, analyzed, and reported can judgments about success be made.

CSAT proposes to use a peer review process, conducted after a knowledge development activity has been completed, to generate data for GPRA reporting purposes. While the details remain to be worked out, the proposal would involve having someone (e.g., the Steering Committee in a multi-site study) prepare a document that describes the study, presents the results, and discusses their implications for substance abuse treatment. This document would be subjected to peer review (either a committee, as is done for grant application review or "field reviewers", as is done for journal articles). The reviewers would be asked to provide ratings of the activity on several scales designed to represent the quality and outcomes of the work conducted (to be developed).[4] In addition, input on other topics (such as what additional work in the area may be needed, substantive and "KD process" lessons learned, suggestions for further dissemination) would be sought. The data would be aggregated across all activities completed (i.e., reviewed) during any given fiscal year and reported in the annual GPRA report.

3.1 PROMOTE THE ADOPTION OF BEST PRACTICES

[4]The ratings would include constructs such as adherence to GFA requirements, use of reliable and valid methods, extent of dissemination activities, extent of generalizability, as well as the principal GPRA outcome constructs.

This "program" involves promoting the adoption of best practices and is synonymous currently with Knowledge Application.[5] Within CSAT, these activities currently include the Product Development and Targeted Dissemination contract (to include TIPS, TAPS, CSAT by Fax, and Substance Abuse in Brief), the Addiction Technology Transfer Centers, and the National Leadership Institute. In FY1999, the Community Action Grant program will be added and in FY2000, the Implementing Best Practices Grant program will be added.

Activities in this program have the purpose of moving "best practices," as determined by research and other knowledge development activities, into routine use in the treatment system. Again simplistically, the immediate success of these activities can be measured by the extent to which they result in the adoption of a "best practice."[6] In order to provide appropriate GPRA measures in this area, CSAT plans to require that all activities that contribute to this goal to collect information on the numbers and types of services rendered, the receipt of the service by the clients and their satisfaction with the services, and whether the services resulted in the adoption of a best practice related to the service rendered.

4. ENHANCE SERVICE SYSTEM PERFORMANCE

As described earlier, this programmatic goal is distinguished from "Promote the adoption of best practices" primarily by its reliance on the Block Grant set-aside for funding and the explicit emphasis on "systems" rather than more broadly on "services." The CSAT activities that fall into this goal are the STNAP and TOPPS. While CSAT has established performance measures for these activities individually, it is waiting for SAMHSA to take the lead in developing SAMHSA-wide measures. In addition, CSAT continues to believe that this goal should be collapsed into the broader goal of "Promoting the adoption of best practices."

EVALUATIONS

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[5]Most, if not all, of the activities conducted under the rubric of technical assistance and infrastructure development are appropriately classified as activities supporting this program goal. Technical assistance activities within GPRA have not been discussed within CSAT. Further, at this time, SAMHSA has a separate program goal for infrastructure development (see "Enhance Service System Performance," below).

[6]Ultimately, the increased use of efficient and effective practices should increase the availability of services and effectiveness of the system in general. However, measures of treatment availability and effectiveness are not currently available. Within existing resources, it would not be feasible to consider developing a system of performance measurement for this purpose.

As defined earlier, evaluation refers to periodic efforts to validate performance monitoring data; to examine, in greater depth, the reasons why particular performance measures are changing (positively or negatively); and to address specific questions posed by program managers about their programs. These types of evaluation are explicitly described, and expected, within the GPRA framework. In fact, on an annual basis, the results of evaluations are to be presented and future evaluations described.

To date, CSAT has not developed any evaluations explicitly within the GPRA framework. The initial requirements will, of necessity, involve examinations of the reliability and validity of the performance measures developed in each of the four program areas. At the same time, it is expected that CSAT managers will begin to ask questions about the meaning of the performance monitoring data as they begin to come in and be analyzed and reported. This will provide the opportunity to design and conduct evaluations that are tied to "real" management questions and, therefore, of greater potential usefulness to CSAT. CSAT will be developing a GPRA support contract that permits CSAT to respond flexibly to these situations as they arise.

On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.

APPENDIX D

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2002

CSAT GPRA Client Outcome Measures for Discretionary Programs

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type 1. INTAKE 2. 6 month follow-up 3. 12 month follow-up

B. DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

a. Any Alcohol |____|____|
b. Alcohol to intoxication (5+drinks in one setting) |____|____|
c. Other Illegal Drugs |____|____|

2. During the past 30 days, how many days have you used any of the following: **Number of Days**

a. Cocaine/Crack |____|____|
b. Marijuana/Hashish, Pot |____|____|
c. Heroin or other opiates |____|____|
d. Non prescription methadone |____|____|
e. PCP or other hallucinogens/ psychedelics, LSD, Mushrooms, Mescaline..... |____|____|
f. Methamphetamine or other amphetamines, Uppers |____|____|
g. Benzodiazepines, barbiturates, other tranquilizers, Downers sedatives, or hypnotics |____|____|

h. Inhalants, poppers, rush, whippets |____|____|

i. Other Illegal Drugs--Specify_____ |____|____|

3. In the past 30 days have you injected drugs? ○ Yes ○ No

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time?

- ○ Shelter (Safe havens, TLC, low demand facilities, reception centers, Other temporary day or evening facility)
- ○ Street/outdoors (sidewalk, doorway, park, public or abandoned building)
- ○ Institution (hospital., nursing home, jail/prison)
- ○ Housed (Own, or someone else's apartment, room, house halfway house, residential treatment)

2. During the past 30 days how stressful have things been for you because of your use of alcohol or other drugs?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely

3. During the past 30 days has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely

4. During the past 30 days has your use of alcohol and other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? [IF ENROLLED: Is that full time or part time?]

- ○ Not enrolled
- ○ Enrolled, full time
- ○ Enrolled, part time
- ○ Other (specify)_____

2. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

2a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

○ Yes ○ No

3. Are you currently employed? [Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work]

- ○ Employed full time (35+ hours per week, or would have been)
- ○ Employed part time
- ○ Unemployed, looking for work
- ○ Unemployed, disabled
- ○ Unemployed, Volunteer work
- ○ Unemployed, Retired
- ○ Other Specify_____

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

	INCOME								
a. Wages	$				,				.00
b. Public assistance	$				,				.00
c. Retirement	$				,				.00
d. Disability	$				,				.00
e. Non-legal income	$				,				.00
f. Other_____(Specify)	$				,				.00

E. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested? |____|____| times

2. In the past 30 days, how many times have you been arrested for drug-related offenses? |____|____| times

3. In the past 30 days, how many nights have you spent in jail/prison? |____|____| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

2. During the past 30 days, did you receive

a. Inpatient Treatment for:		No	Yes ±	**If yes, altogether** for how many nights (DK=98)
i. Physical complaint	°	°		_____
ii. Mental or emotional difficulties		°	°	_____
iii. Alcohol or substance abuse		°	°	_____

b. Outpatient Treatment for:		No	Yes ±	**If yes, altogether** how many times (DK=98)
i. Physical complaint	°	°		_____
ii. Mental or emotional difficulties		°	°	_____
iii. Alcohol or substance abuse		°	°	_____

c. Emergency Room Treatment for:		No	Yes ±	**If yes, altogether** for how many times (DK=98)
i. Physical complaint	°	°		_____
ii. Mental or emotional difficulties		°	°	_____
iii. Alcohol or substance abuse		°	°	_____

H. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

- ○ Male
- ○ Female
- ○ Other (please specify) _____

2. Are you Hispanic or Latino?

○ Yes ○ No

3. What is your race?

- ○ Black or African American
- ○ Asian
- ○ American Indian
- ○ Native Hawaiian or other Pacific Islander
- ○ Alaska Native
- ○ White
- ○ Other (Specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|
Month / Day / Year

APPENDIX E

WORKING DEFINITIONS

Client refers to a drug user, their sex partner(s), and their children or involved family member. A client may be counted only once and must have a client identifier assigned.

Client Encounter refers to the face-to-face exchanges that occur with a client. Multiple encounters may be reported for one client per year.

Community Based Organization refers to organizations that 1) are located in a given neighborhood or community, 2) have access to hard-to-reach members of the African American, Hispanic/Latino populations and other racial/ethnic minority communities, 3) are organized to address the needs of this population, and 4) can demonstrate the capability to bring together a network of providers to plan, coordinate, and implement comprehensive innovative treatment and other related services.

Comprehensive Services refers to a broad array of treatment interventions, approaches, and support activities that address the client's addiction and HIV/AIDS risk or status in the context of his or her social, psychological, economic, and medical needs. These include services for (but are not limited to) physical and/or sexual abuse trauma issues, co-occurring disorders (mental illness and substance abuse), safe housing, transportation, child care, and vocational/educational training and employment. This also refers to appropriate assessment tools and protocols for identifying client needs, establishing treatment plans, and implementing high quality treatment services.

Cross-site refers to prospective or pre-designed analysis of a common set of data collected across

projects (funded under this GFA) unique in design and activities. Cross-site differs from multi-site evaluations which collect data from a number of sites that are implementing the same program design. These cross-site activities are designed to respond to the GPRA Act of 1993.

Culturally Competent - See Appendix D in Part II.

Expansion of Services refers to an increase in the availability of treatment slots/beds for a larger number of clients (specifically, hard to reach and undeserved) in outpatient and/or residential settings.

HIV/AIDS Services refers to all services provided to HIV positive individuals in conjunction with substance abuse treatment. These services can include, but are not limited to, the following: support services such as case management, and transportation assistance, nutrition services and day/respite care; continuation of health care insurance coverage through a Health Insurance Continuation Program (HICP); and pharmaceutical treatments through the AIDS Drug Assistance Program (ADAP).

Indigenous Organizations are organizations that evolved from and are located within the communities (both in terms of racial or ethnic populations and in terms of targeted high risk groups) that they serve. An indigenous organization will have a board composed of more than 50 percent of the racial or ethnic minority population to be served, and significant representation from members of the target populations (where significant representation requires a minimum of 25 percent of the board).

Integrated Services/Service Integration refers to a broad range of strategies for minimizing/eliminating the burden on high-risk clients (with complex and multiple needs) who are least able (financially, physically, or

emotionally) to cope with the fragmentation of services provided by different organizations, professionals, service systems and diagnosticians who share the same target population. Strategies include (but are not limited to) strengthening coordination within and between service systems; instituting multi-disciplinary approaches for assessing and treating the total person; and developing a comprehensive system of care based on formal collaborative agreements among service agencies and/or systems.

New Services refers to services that currently do not exist within the applicant's organization and, therefore, are not available to the target population.

Outreach Contact is defined as a brief contact with a potential client and is not documented in a client record; it may be anonymous. Outreach contacts may include, among other things, distribution of condoms, or educational materials and/or brief "on-the-street" risk reduction interventions. (This does not include educational presentation or workshop participant count). Outreach contacts may be reported as estimates because an actual count may be difficult to obtain.

Program Admissions refers to persons who have gone through the intake process and received initial services, i.e., have been "admitted" into the program.

Support, in the term "Letters of Coordination/Support," refers to signed agreements between participating organizations that will commit resources such as: dollars, services, service delivery units, staff, equipment, facilities, technical assistance, training, and the like. Such agreements must specify the range, type, and duration of services to be provided. Also, these services must be individualized and gender, age, developmentally, and culturally appropriate.